

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026552

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318

1003

6222

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUN 21 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. Louis

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION DOA Homer G. Phillips

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
4361a West Belle Pl.,

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

First

Middle

Last

CATHERINE

E.

YOKLEY

4. DATE OF DEATH

Month

Day

Year

June 10, 1963

5. SEX

Female

6. COLOR OR RACE

Negro

7. Married

Widowed ☒

8. DATE OF BIRTH

7-29-1876

9. AGE (last birthday)

86

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nil

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
St. Louis, Mo.,

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

Joseph Bischoff

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)

No

NO.

17. INFORMANT

Address

Mrs Zamantha Lewis- 4361a West Belle Pl.,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arterio Sclerotic Heart Disease

DUE TO (b)

Arterio Sclerosis

DUE TO (c)

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

to

and last saw her alive on

Death occurred at

845 A

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

Helen L. Taylor, Coroner

1300 Clark Ave.

6-12-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

Removal

6-15-63

Greenwood Cemetery

St. Louis County, Mo.,

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

G. Wade Granberry

4202 Finney Ave.,

JUN 12 1963

Road Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.